



CONSENT FOR RELEASE OF INFORMATION

State Form 53207 (1-07) / FI 2511
FAMILY AND SOCIAL SERVICES ADMINISTRATION
DIVISION OF FAMILY RESOURCES

County office

TO:

Name	Telephone number ()	E-mail address
Address (number and street, city, state, and ZIP code)		

REGARDING:

Name	Date of birth (month, day, year)	Social Security number XXX-XX-
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I, _____, the undersigned, hereby voluntarily authorize and expressly consent for the release of information as checked below, by the Division of Family Resources for the determination of eligibility for correctness of benefits for:

Name	Name
Name	Name
Name	Name

The information released / requested / exchanged will be used to determine the correctness of benefits for eligibility of Food Stamps, Medicaid / Hoosier Healthwise, Temporary Assistance for Needy Families (TANF), Child Care Funds, or Work Participation Compliance.

Please release the following information designated below by a check mark and my initials:

- ☐ _____ Identifying information (birth records, vital records, school records)
- ☐ _____ Earned and unearned Income
- ☐ _____ Shelter and utility expenses
- ☐ _____ Information about benefits/payments received from another agency or third party (social service agency, township trustee)
- ☐ _____ Verification of medical expense and/or third party liability co-payment
- ☐ _____ Financial asset information (such as bank accounts, retirement accounts, stocks/bonds, life insurance policies, trust accounts and includes ownership, value and beneficiary)
- ☐ _____ Other (specify) _____

I am the individual to whom the information/record applies or legal guardian of the individual. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison or may face other penalties, or both.

Check appropriate boxes below:

- ☐ I have read this form and understand its meaning.
- ☐ This form was read to me and I understand its meaning.
- ☐ This form was explained to me by an interpreter and I understand its meaning.
- ☐ All the blanks were filled in before the form was signed by me.

THIS AUTHORIZATION IS EFFECTIVE UNTIL I REVOKE IT IN WRITING OR 90 DAYS AFTER THE DATE I SIGN BELOW, WHICHEVER OCCURS FIRST.

Signature	Relationship to client	Date (month, day, year)
(If signed by a mark "X"; list signature, name, and address of competent witness age 21 and over.)		
Signature of witness	Printed name	Date (month, day, year)
Address (number and street, city, state, and ZIP code)		